U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 17 April 2006

CASE Nos.: 2002-BLA-5034

In the Matter of:

CLYDE C. BELCHER,
Claimant

v.

WESTMORELAND COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Roger D. Foreman, Esquire
For Claimant

William S. Mattingly, Esquire
For Employer

BEFORE: Thomas M. Burke
Associate Chief Administrative Law Judge

DECISION AND ORDER- AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* (the Act). Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Regulations.

The Act provides benefits to persons totally disabled due to pneumoconiosis and to certain survivors of persons who had pneumoconiosis and were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a chronic dust

disease of the lungs, including respiratory and pulmonary impairments arising out of coal mine employment, and is commonly referred to as black lung.

The Director, Office of Workers' Compensation Programs, referred this case to the Office of Administrative Law Judges for a formal hearing on March 1, 2002.[1] DX 35. A hearing was held before the undersigned Administrative Law Judge in Beckley, West Virginia (*see* "Background and Procedural History," *infra*, for a complete account of the procedural history of this case).

At the hearing Director's Exhibits 1- 35 were admitted without objection. In addition, the following exhibits were determined to be in compliance with the evidentiary limitations found at 20 C.F.R.§ 725.414 and were also admitted into evidence:

CX 1 – 7/12/01 CT report of Dr. Maki and his curriculum vitae
CX 2 – Dr. Cappielo's interpretation of x-ray dated 4/18/01
CX 3 – Dr. Cappielo' interpretation of CT scan dated 7/1/02
CX 4 – Dr. Cappielo's curriculum vitae
CX 5 – Dr. Ahmed's interpretation of x-ray dated 4/18/01
CX 6 – Dr. Ahmed's interpretation of CT scan dated 7/1/02
CX 7 – Dr. Ahmed's curriculum vitae
CX 8 – 9/19/02 report of Dr. Robert Cohen
CX 9 – Dr. Cohen's curriculum vitae
CX 10 – Dr. Cohen's supplemental opinion dated 6/1/04
CX 11 – X-ray interpretation dated 4/1/02 by Dr. Robert Smith and curriculum vitae
CX 12 – Dr. Shipley's interpretation of CT scan dated 7/1/02
CX 13 – Dr. Spitz' interpretation of CT scan dated 7/1/02
CX 14 – Medical records of Dr. Lynn N. Smith
CX 15 – Dr. Cohen's supplemental opinion dated 11/9/04
EX 2 – Dr. Wiot's interpretation of x-ray dated 5/24/01
EX 3 – Dr. Crisalli's report dated 5/20/02 as well as pulmonary function and blood gas tests dated 4/1/02
EX 4 – Dr Scott's interpretation of x-ray dated 4/18/01 and his curriculum vitae; and Dr. Wheeler's interpretation of x-ray dated 4/1/02 and his curriculum vitae.
EX 8 – Dr. Zaldivar's supplemental opinion dated 8/5/02
EX 10 – Dr. Crisalli's supplemental opinion dated 8/8/02
EX 14 – Dr. Crisalli's deposition testimony dated September 30, 2002
EX 15 – Dr. Zaldivar's deposition testimony dated October 1, 2002
EX 16 – Dr. Wheeler's interpretation of CT scan dated 7/1/02
EX 17 – Dr. Scott's interpretation of CT scan dated 7/1/02
EX 18 – Dr. Scatarige's interpretation of CT scan dated 7/1/02
EX 19 – Claimant's answers to supplemental interrogatories
EX 23 – Dr. Zaldivar's supplemental opinion dated May 24, 2004
EX 24 – Dr. Zaldivar;s deposition testimony dated June 28, 2004
EX 26 – Dr. Zaldivar's supplemental opinion dated October 4, 2004
EX 27 – Employer's exhibit list

[1] The following references will be used herein: TR for transcript, CX for Claimant's exhibit, DX for Director's exhibit EX for Employer's exhibit

At the hearing the record was held open for the receipt of deposition testimony by Dr. Smith and for closing briefs. Dr. Smith's deposition testimony was received by this office on January 6, 2005. It was marked as EX 28 and is hereby admitted into evidence.

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

ISSUES

1) Whether the Claimant's application for benefits was timely filed.
2) Whether the Claimant has pneumoconiosis;
3) Whether the Claimant's pneumoconiosis arose out of coal mine employment;
4) Whether the Claimant is totally disabled.
5) Whether the Claimant's total disability is caused by pneumoconiosis;
6) The number of dependents for purposes of augmentation of benefits; and
7) Whether Claimant has proven one of the conditions of entitlement previously adjudicated against him pursuant to 20 C.F.R. § 725.309.

Background and Procedural History[2]

Claimant, Clyde C. Belcher, filed his initial claim for benefits on November 17, 1987. DX 33. After a hearing before Administrative Law Judge, Robert M. Gleason, a Decision and Order denying benefits was issued on September 20, 1989. DX 33(29). No further action was taken in regard to this claim. Claimant's present claim for benefits was filed on January 22, 2001. DX 1. On January 24, 2003, the District Director issued a Proposed Decision and Order Awarding benefits. DX 28. Since the Employer continued to controvert its liability for payment of benefits in this case, the Department of Labor indicated by letter dated February 20, 2002 that the Black Lung Disability Trust Fund would begin payment of benefits until the claim was finally decided. DX 32. By letter dated January 29, 2002, the Employer requested a hearing and on March 1, 2002 this case was referred to the Office of Administrative Law Judges for hearing and adjudication.

At the hearing Claimant testified that he began working in the mines at age seventeen and that ninety percent of his coal mine employment had been at the face. Tr. 30. The last ten years of his coal mine employment had been at Westmoreland Coal Company where he had worked on the belt. Tr. 30. Claimant indicated that his breathing problems had begun approximately in

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[2] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718 (*i.e.* March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because Claimant's last exposure to coal mine dust occurred in West Virginia, this claim arises within the territorial jurisdiction of the United States Court of Appeals for the Fourth Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

1969. At that time he had been setting jacks on a continuous miner where he had been exposed to a lot of dust. Tr. 30-31. He testified that he stopped working in the mines in approximately March of 1986 because of a mine injury. Tr. 35-36. Claimant testified that he had smoked cigarettes for about thirteen years between 1946 and 1959 at the rate of about one half pack of cigarettes or less per day. Tr. 37-38. He stated that his breathing problems prevent him from climbing more than one flight of steps and that he uses an inhaler so that he can walk. Tr. 39-40. Claimant testified that Dr. Smith had been his treating physician since 1984. Tr. 40. He indicated that he and his wife had adopted their granddaughter when she was eight years old and that she was 23 years old at the time of the hearing. He testified that she had graduated from high school in 1999 and that she was still in college on a fulltime basis. Tr. 40-42. In regard to other health problems Claimant testified that he had experienced a heart attack in 1992 and bypass surgery in 1994. He indicated that he still had shortness of breath after the bypass surgery. Tr. 53-54.

Length of Coal Mine Employment

The parties have stipulated to 33 years of coal mine employment. (TR 8) I find that this stipulation is supported by the record and therefore determine that Claimant worked at least 33 years as a coal miner.

Date of Filing

The Claimant's application for benefits was filed on January 22, 2001. (DX 1). Although Claimant's application indicates that it was signed on January 16, 2001, it was not received or date stamped by the Department of Labor until January 22, 2001. Further, Claimant's testimony supports a determination that his intention was that the application be filed on January 22, 2001 and that he did not mail the application until after January 20, 2001. (TR. 47). Therefore, it is determined that the date of filing of Claimant's current application for benefits is January 22, 2001.

Timeliness Of Filing

Employer argues that the Claimant's subsequent claim for benefits is not timely filed since it was filed more than three years after a diagnosis of total disability due to pneumoconiosis and therefore should be barred by the time limitations of 20 C.F.R. § 725.308(a).

20 C.F.R. § 725.308(a) provides that a miner's claim for black lung benefits must be filed within three years after a medical determination of total disability due to pneumoconiosis is communicated to the miner. The Benefits Review Board has interpreted the limitation of action period as not applying to subsequent claims such as the claim filed here. The Board reasoned in *Faulk v. Peabody Coal Co*., 14 B.L.R. 1-18 (1990) and *Andryka v. Rochester & Pittsburgh Coal Co.*, 14 B.L.R. 1-34 (1990), that the filing of subsequent claims need not comply with the statute of limitations because the purpose of the statute of limitations is satisfied by ensuring that the Employer is provided notice of the current claim and the potential for liability for future claims.

In a more recent case arising in the Fourth Circuit, *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004) (en banc), the Board citing to Fau*lk*, again declined to apply the three year statute of limitations to a subsequent claim filed under 20 C.F.R. § 725.309 (2001). Recently, the Board in *Stoliza v. Barnes and Tucker,* 23 BLR 1-____, BRB No. 05-0209 BLA (Oct 26, 2005) acknowledged by footnote the viability of its holdings in *Andryka* and *Faulk* that the three-year statute of limitation period does not apply to subsequent claims.

The Fourth Circuit Court of Appeals has not issued a published opinion discussing this issue but it has recently issued two unpublished decisions. In *Bethenergy Mines, Inc. v. Cunningham*, Case No. 03-1561 (4th Cir. July 20, 2004) (unpub.), the court held that Employer waived its argument that the miner's claim was barred by the three year statute of limitations because Employer "stipulated at the first hearing before the ALJ that Cunningham's claim was timely." The court declined to address the BRB's "timeliness rule" but did reference the Director's position as being similar to that of the Tenth Circuit in *Wyoming Fuel Co. v. Director, OWCP,* 90 F.3d 1502 (10th Cir. 1996). In *Westmoreland Coal Co. v. Amick*, Case No. 04-1147 (4th Cir. Dec. 6, 2004) (unpub.), the court rejected the Board's holding that the three year limitations period set forth at 20 U.S.C. § 932(f) and 20 C.F.R. § 725.308(a) does not apply to subsequent claims filed under 20 C.F.R. § 725.309.

Employer argues the BRB's decisions in *Andryka* and *Faulk* should not be applied here in light of the decision of the Fourth Circuit in *Amick,* and that this subsequent claim be dismissed as not having been filed within three years after a medical determination of total disability from pneumoconiosis was communicated to the Claimant. The medical determinations that Employer argues should be found to trigger the three year limitation are a report by Dr. Rasmussen admitted into the record as part of the Claimant's first claim, and a statement to Claimant by his treating physician, Dr. Lynn Smith.

The report of Dr. Rasmussen reference by the Employer is dated January 8, 1988. It states that "[t]he patient has minimal to moderate pulmonary impairment which would render him totally disabled for heavy manual labor, including his former employment as a beltman with its attendant requirement for heavy manual labor." DX 33-9, p. 4. The report was considered by the Administrative Law Judge in rendering his September 20, 1988 decision denying benefits. The ALJ found that Dr. Rasmussen's finding of total disability "can not be supported by his underlying documentation." DX 33-29, p. 7. Thus Dr. Rasmussen's report was found to be unreasoned in the earlier claim and therefore can not now be considered as sufficient to trigger the statute of limitations. Further, the Court in *Amick* would find Dr. Rasmussen's report to be insufficient to trigger the statute of limitations because it was part of the record considered in the decision finding Claimant not to be totally disabled from pneumoconiosis. The Court in *Amick* explained that, in the context of subsequent claims, it agreed with the Tenth Circuit's reasoning in *Wyoming Fuel Co., supra,* that:

> A final finding by an Office of Workers' Compensation Program adjudicator [or other final adjudicator] that the claimant is not totally disabled due to pneumoconiosis repudiates any earlier medical determination to the contrary and renders prior medical advice to the contrary ineffective to trigger the running of the statute of limitations.

Accordingly, Dr. Rasmussen's report is not found to be a medical report that would trigger the statute of limitations and preclude this claim.

The medical determination by Dr. Smith relied on by the Employer as triggering the statute of limitations was referenced in the cross-examination of Claimant. Claimant was asked by Employer's attorney whether Dr. Smith had ever told him he was disabled by black lung disease, and the Claimant responded, "yes…he told me a long time ago." Claimant explained: "[Dr. Smith] asked me, 'did I ever,' you know, 'apply for Black Lung?' And he said, that's what he said all along, "you've got that." TR. 51, 52.

Dr. Smith's comments, as recalled by Claimant in his testimony, that he should apply for black lung benefits because he has black lung, can hardly be considered a "medical determination" as referenced 20 C.F.R. § 725.308(a). At the very least, the requisite "medical determination" has to be found to be well reasoned. See for example the Board's decision in *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.), where the Board interpreted *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602 (6th Cir. 2001) as requiring that "the administrative law judge must determine if (the physician) rendered a well-reasoned diagnosis of total disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner.'"

Thus, the Employer has not shown that the Claimant's present application for benefits, filed on January 22, 2001, was not timely filed.

Responsible Operator

Employer no longer contests the determination that Westmoreland Coal Company is the properly named responsible operator in this case as it was the last coal mine employer for whom Claimant worked for a cumulative period of at least one year. (TR 8)

Dependents

Claimant has been married to his wife, Loretta since 1954 and she is a dependents spouse pursuant to 20 C.F.R. §725.205. DX 7. In addition, the record indicates that the Claimant has an adopted daughter, Jessica, who was born on August 10, 1981. DX 8,9. Claimant testified that Jessica was a full time college student at the time of the hearing. TR. 40-43. Jessica would be a dependent for augmentation of benefits until the age of 23 if enrolled as a full time student pursuant to the regulations at 20 C.F.R. §725.209.

Subsequent Claim

The present claim, which was filed on January 22, 2001, was filed more than one year after the Claimant's previous claim was finally denied. Therefore, the regulations at 20 C.F.R. §725.309 deem the present claim a "subsequent" claim. The regulations provide that a subsequent claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the final denial of the previous claim. The

regulations further provide that the "subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement." See 20 C.F.R. §725.309(d)(3). Because Claimant has not previously established any condition of entitlement, the new evidence submitted with the present claim will be reviewed to determine whether it establishes any condition of entitlement. If the new evidence does establish at least one condition of entitlement, then I will review all evidence of record to determine whether Claimant has established entitlement to benefits.

Medical Evidence

Chest X-rays

Exhibit Number	Date of X-ray	Physician/ Qualifications	Diagnosis
DX 33(25)	2/3/83	Bassali	Negative
DX 33(25)	12/5/83	Leef	Negative for pneumoconiosis
DX 33(11)	1/8/88	Speiden/BCR,B	1/0, s/p, 4 zones
DX 33(12)	1/8/88	Gaziano	Negative
DX 33(13)	1/8/88	Sargent/BCR,B	Negative for pneumoconiosis
DX 33(24)	9/21/88	Zaldivar/B	Negative
DX 33(25)	9/21/88	Duncan/BCR,B	0/1, p/p, 4 zones
CX 2	4/18/01	Capiello/BCR,B	2/1 p/s
CX 5	4/18/01	Ahmed/BCR,B	2/1 p/s
EX 4	4//18/01	Scott/BCR,B	Negative for pneumoconiosis
DX 16	5/24/01	Patel/BCR,B	1/1 p/s, 6 zones
DX 16	5/24/01	Gaziano	Quality=1 (Reading for quality only)
EX 2	5/24/01	Wiot/BCR,B	Negative for pneumoconiosis
CX 11	4/1/02	Smith/BCR,B	1/1, p,s 6 zones
EX 4	4/1/02	Wheeler/BCR,B	Negative

Pulmonary Function Studies[3]

Exhibit	Date	Age	Height	FEV 1	MVV	FVC	Qualify
DX 33	2/13/83	52	68"	3.24	138	4.16	No
DX 33	12/5/83	53	67"	3.35	141	4.33	No
DX 33	1/8/88	57	68"	3.11	137	4.03	No
DX 33	7/20/88	58	67"	3.03	156	3.99	No
DX 33	9/21/88	58	67"	2.99	156	4.22	No
DX 27	4/18/01	70	67"	2.37 2.43*	118 119*	3.60 3.64*	No
DX 11	5/24/01	70	67"	2.08 2.31*	93 104*	3.26 3.43*	No
EX 3	4/1/02	71	67"	2.34 2.50*	97	3.48 3.52*	No

*post-bronchodilator

Arterial Blood Gas Studies

Exhibit	Date	PO2	PCO2	Qualify
DX 33	2/13/83	82.6	37.8	No
DX 33	1/8/85	76 74*	36 33*	No No
DX 33	9/21/88	97 95*	32 32*	No No
DX 27	4/18/01	98 64*	29 30*	No Yes
DX 11	5/24/01	74 58*	33 32*	No Yes
DX 27	4/1/02	90	36	No

* after exercise

[3] As there is a discrepancy in recorded height, qualification of the vent studies is based on the average of Claimant's reported heights which is 67.25 inches.

Medical Reports

Dr. D.L. Rasmussen

Dr. Rasmussen performed a physical examination of the Miner on May 24, 2001 at the request of the Department of Labor. DX 12. He considered the Claimant's occupational, medical and smoking histories, as well as his reported symptoms which included exertional shortness of breath, chronic cough, wheezing, nocturnal dyspnea, and chest pain. On physical examination he noted that breath sounds were moderately reduced. Clinical testing included a chest x-ray, which was interpreted by Dr. Patel, a B reader, as positive for pneumoconiosis, as well as a pulmonary function study, blood gas test and an EKG. The pulmonary function studies revealed minimal, reversible obstructive insufficiency. Although resting blood gases were normal, the exercise study showed marked impairment in oxygen transfer and indicated that the Claimant was at least moderately hypoxic. Dr. Rasmussen concluded that the studies overall indicated marked loss of lung function as reflected by Claimant's significantly reduced single breath diffusing capacity and the impairment in oxygen transfer during exercise. He found that the degree of impairment would disable the Claimant from returning to his last coal mine employment. Dr. Rasmussen cardiopulmonary diagnoses included coalworkers' pneumoconiosis and chronic obstructive pulmonary disease/emphysema both of which he attributed to his coal mine dust exposure. He also diagnosed arteriosclerotic heart disease which was due to non-occupational factors. He determined that the only significant risk factor for Claimant's impaired lung function was his coal mine dust exposure. He noted that the Claimant's history of cigarette smoking was minimal and that the pattern of his impairment more strongly suggested that it was the result of coal mine dust exposure.

Dr. Rasmussen had previously examined the Claimant on January 8, 1988 in regard to his initial claim for benefits. In addition to the physical examination, a chest x-ray, pulmonary function study, blood gas test and EKG were considered. He diagnosed coal workers pneumoconiosis at that time, and found that the Claimant had minimal to moderate pulmonary impairment which would disable him from heavy manual labor

Dr. George L. Zaldivar

Dr. Zaldivar performed a physical examination of the Miner on April 18, 2001. DX 27. Dr. Zaldivar is Board Certified in Internal Medicine, Pulmonary Diseases, and Sleep Disorders. He reviewed the Claimant's occupational, medical and smoking histories as well as his chief complaint of shortness of breath. On physical examination he noted that the lungs were clear to auscultation and percussion, without wheezes, crackles or rales. Clinical testing included a chest x-ray, pulmonary function study, blood gas test and EKG. He concluded that the Claimant did not have coal worker's pneumoconiosis nor any other dust disease of the lungs. He stated that the Claimant did have a respiratory impairment due to a low diffusing capacity which would disable him from performing his usual coal mine employment. He attributed this respiratory disease to coronary artery disease resulting in interstitial edema. He noted that the diffusion impairment was not present in 1988, two years after the Claimant terminated his coal mine

employment. He concluded therefore, that the diffusion abnormality could not be attributed to dust deposition in the lungs. Dr. Zaldivar reiterated this point during his deposition testimony which was taken on October 1, 2002 and June 28, 2004. Dr, Zaldivar indicated that a miner would have to show impairment from pneumoconiosis at the time his coal mining ceased in order for the disease to progress later in his life. EX 25(35-37)

In a supplemental opinion dated August 5, 2002 Dr. Zaldivar reviewed available medical records, which included his previous examination of the Claimant on October 3, 1988. EX 8, DX 33(24). At that time Dr. Zaldivar had found no evidence of pneumoconiosis. He diagnosed minimal airway obstruction resulting from the Claimant's smoking habit, but concluded that Claimant was not totally disabled from his coal mine employment. In the August 5, 2002 supplemental opinion Dr. Zaldivar still found no evidence of coal workers' pneumoconiosis, but indicated that a pulmonary impairment was present which manifested itself by a low diffusing capacity. He attributed this to the Claimant's cardiac disease and coronary bypass surgery. He indicated that the Claimant was disabled from a pulmonary standpoint due to this condition and would be incapable of performing his usual coal mine employment.

In supplemental opinions dated May 24, 2004 and October 4, 2004 Dr. Zaldivar reviewed additional medical records including the report of Dr. Robert Cohen. EX 23, 26. Dr. Zaldivar indicated that his previous opinions regarding the Claimant's pulmonary condition, disability and cause of his disability remained unchanged. The record includes the deposition testimony of Dr. Zaldivar, taken on October 1, 2002 and June 28, 2004, in regard to these opinions. EX 15, 24.

Dr. Robert J. Crisalli

Dr. Crisalli, who is Board Certified in Internal Medicine and Pulmonary Diseases, performed a pulmonary evaluation of the Miner on May 20, 2002. EX 3. He reviewed the Miner's occupational, medical and smoking histories as well as his reported symptoms which included shortness of breath, cough, occasional angina and paroxysmal nocturnal dyspnea, and orthopnea. Dr. Crisalli reported that physical examination of the lungs was normal.
A chest x-ray was considered which was initially interpreted by Dr. Smith, a B-reader and Board Certified radiologist as positive for pneumoconiosis. This x-ray was reread by Dr. Wheeler, also a Board Certified radiologist and B-reader, as negative for pneumoconiosis. Pulmonary function testing showed a diffusion defect and resting blood gas tests were normal. Exercise blood gas testing was not performed. Available medical records were also considered. Dr. Crisalli states that the Claimant's "chest x-ray shows no evidence of coal worker's pneumoconiosis, taking all of the x-ray reports as a whole" and therefore he concludes that there is insufficient objective evidence for a diagnosis of coal worker's pneumoconiosis. He did conclude that the Claimant had significant respiratory impairment from the standpoint of oxygen transfer, and he would be unable to perform his regular coal mining job. Dr. Crisalli indicated that Claimant's disabilitiy was not related to his coal mine dust exposure. He did not reach a conclusion about what the cause was, indicating that the Claimant needed further testing to determine the cause.

Dr. Crisalli reviewed additional medical records from 1988 and 1989, relevant to the Claimant's earlier claim for benefits, as indicated in his report dated August 21, 2002. EX 10. He indicated that there was nothing in these records which would cause him to change his

previously stated opinion. Dr. Crisalli's deposition testimony was taken on September 30, 2002, regarding his opinions as stated in his reports. EX 14.

Dr. Robert Cohen

Dr. Cohen provided a consultative report dated September 19, 2002, wherein he reviewed the available medical records in this case. CX 8. Dr. Cohen is Board Certified in Internal Medicine and Pulmonary Diseases and is also a Board Certified Medical examiner and a B reader of chest x-rays. Dr. Cohen concluded that the Claimant did have coal workers' pneumoconiosis related to his history of coal dust exposure. In support of his opinion he cites Claimant's 33 year history of dust exposure and his negligible smoking history. He also points out his symptoms of progressive shortness of breath, cough and wheezing which have been documented in reports for 15 to 20 years. He further cites Claimant's pulmonary function and blood gas testing which show progressive diffusion impairment and significant gas exchange abnormalities with exercise. Dr. Cohen indicated that the Claimant "clearly did not have the pulmonary function capacity to perform his last coal mining job. He attributed Claimant's impairment to his more than 33 years of exposure to coal mine dust. Dr. Cohen stated that "it is a classic finding that the interstitial lung disease caused by coal mine dust causes diffusion impairment and gas exchange abnormalities with exercise. Dr. Cohen's report includes a thorough discussion of recent medical literature regarding the effect of coal mine dust exposure on the development of occupational lung disease in coal miners. His curriculum vitae also demonstrates a high degree of proficiency in the area of occupational lung disease by the large number of published articles and lectures which he has given on related topics.

In a supplemental report dated June 1, 2004, Dr. Cohen reviewed additional medical records in this case, as well as deposition testimony of Drs. Zaldivar and Crisalli. CX 10. He reported that his opinion remained the same in that Claimant suffered from coal workers' pneumoconiosis and that he was totally disabled due to his chronic respiratory condition related to his 33 year history of coal mine employment. In particular, Dr. Cohen explained that he disagreed with Dr. Zaldivar's opinion that Claimant's diffusion impairment and abnormal gas exchange was due to heart disease and Dr Crisalli's opinion that it was due to some other undetermined and undiagnosed lung condition. In a supplemental opinion dated November 9, 2004, after reviewing a later report by Dr. Zaldivar, Dr. Cohen again reiterated his earlier opinions. CX 15.

Dr. Lynn N. Smith

The record includes the office notes of Dr. Smith regarding his treatment of the Claimant between July 18, 2001 and August 22, 2001. CX 14. Dr. Smith's deposition testimony was taken on December 22, 2004. EX 28. Dr. Smith testified that he was Board Certified in Internal Medicine as well as in clinical Densitometry, which involves the treatment of osteoporosis. He stated that he is the Claimant's treating physician and that he first saw the Claimant on November 1, 1994 and has treated him regularly since that time. Dr. Smith testified that he diagnosed the Claimant with coal worker's pneumoconiosis based primarily on his chest x-rays, CT scan interpretations, his history of more than thirty years in coal mine employment which was primarily underground, and the evidence of progressive pulmonary disease. He found no

other historical factors supporting any other reason for his pulmonary disease, and he found Claimant's history of cigarette smoking to be insignificant. He also found no signs of congestive heart failure in the Claimant and did not believe that cardiac disease was the cause of his pulmonary impairment. Dr. Smith testified that the Claimant would be disabled from his last coal mine employment due to several factors which included his pulmonary disease and his coronary artery disease. He concluded that the Claimants pulmonary disease contributed to his total impairment but did not offer an opinion on whether it would be totally disabling if considered alone.

Joseph Sobieski

Dr. Sobieski, who is Board Certified in Internal Medicine, reviewed records pertinent to Claimant's original claim for benefits as indicated in his report dated May 6, 1989. DX 33(26). He found that Claimant did not have pneumoconiosis. He did diagnose minimal respiratory impairment secondary to cigarette smoking but concluded that the Claimant was not totally disabled from his last coal mine employment.

Dr. Gregory J. Fino

Dr. Fino reviewed available medical records regarding Claimant's previous claim for benefits as indicated in his report dated May 12, 1989. DX 33(26). Dr. Fino, who is Board Certified in Internal Medicine and Pulmonary Diseases found insufficient objective medical evidence for a diagnosis of pneumoconiosis at that time and concluded that Claimant did not have any respiratory impairment.

R.W. Rechtenwald, II

Dr. Rechtenwald performed a physical examination of the Claimant on December 5, 1983. DX 33(25). He considered a chest x-ray and a pulmonary function study. He found no evidence of occupational pneumoconiosis and no pulmonary functional impairment.

Other Medical Evidence

The record includes eight interpretations of a CT scan of the Claimant's chest on July 1, 2002 which have been submitted as other evidence. Dr. Maki reviewed the July 1, 2002 CT scan and noted that there were parenchymal findings consistent with fibrosis – likely occupational exposure. CX 1. Dr. Enrico Cappiello reviewed the CT and found changes of chronic obstructive pulmonary disease and diffuse underlying interstitial fibrosis consistent with pneumoconiosis. CX 3. Dr. Afzal Ahmed found interstitial fibronodular changes consistent with pneumoconiosis. CX 6. Dr. Ralph T. Shipley found minimal findings consistent with simple coal worker's pneumoconiosis. CX 12. Harold B. Spitz indicated, after his review of the CT that there may be evidence of simple coal worker's pneumoconiosis, with small nodules in the upper lungs. Dr. Paul S. Wheeler, Dr. William W. Scott, Jr. and Dr. John C. Scatarige each reviewed the CT and concluded that there was no evidence of coal workers' pneumoconiosis.

The record includes a decision by the West Virginia occupational pneumoconiosis board dated July 21, 1988, awarding the Claimant 5% disability due to occupational pneumoconiosis. DX 33(25).

The record also includes hospital records from Charleston Area Medical Center where the Claimant had been hospitalized for a cardiac catheterization which was performed on November 18, 1994. The surgeon was Howard J. Stanton, M.D. The preoperative and postoperative diagnoses were critical triple vessel coronary artery disease with recurrent accelerating angina, positive stress test, and previous inferior infarction.

Entitlement: Determination of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." [4] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.[5] 20 C.F.R. § 718.201. The term "arising out of coal

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[4] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996) (*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995) at 314-315.

[5] Regulatory amendments effective January 19, 2001, state:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment

mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." According to 20 C.F.R. §718.2(2001), the amended definition of pneumoconiosis applies to all Part 718 claims, regardless of their filing dates. See National Mining Ass'n. et al. v. Dept. of Labor, 292 F. 3d 849 (D.C. Cir. 2002).

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of any of the pertinent presumptions;[6] or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

In *Island Creed Coal Co. v. Compton,* 211 F. 3d 203 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis.

Chest X-ray Evidence

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Where two or more x-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the x-rays must be considered. § 718.201(a)(1).

While a judge is not required to defer to the numerical superiority of x-ray evidence, it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) *citing Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence which he deems to be most probative, even where it is contrary to the numerical majority. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984).

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significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

[6] The presumptions contained in §§718.304-718.306 are inapplicable in this case and therefore will not be discussed further.

The x-ray evidence has previously been summarized. The record includes eight interpretations of three x-rays taken since 2001. Dr. Gaziano's reading of the May 24, 2001 x-ray was done only in regard to film quality. He found the film quality to be a "1" which would indicate good or acceptable quality. The other seven x-ray interpretations were all performed by radiologists who were both Board Certified and B readers. Four of these readings were found to be positive and three were interpreted as negative. There is one positive and one negative reading of the May 24, 2001 and the April 1, 2002 x-rays, while the April 18, 2001 x-ray indicates two positive interpretations and one negative reading. All of these x-rays were performed within the span of one year. Therefore, I do not find any of the x-rays to be more probative based on it being more recent. In addition, all of the readings were performed by highly qualified Board Certified radiologists and B-readers. Although there is disagreement among the qualified experts in regard to whether pneumoconiosis has been established, a preponderance of the readings are positive. Therefore, I find that the x-ray evidence does support a determination of pneumoconiosis.

Autopsy or Biopsy Evidence

Pursuant to § 718.202(a)(2), autopsy or biopsy evidence may provide the basis for a finding of pneumoconiosis. No such evidence has been submitted in this case. Therefore this provision is not applicable.

Medical Opinions

Lastly, under § 718.202(a)(4) a finding of pneumoconiosis may be based on the opinion of a physician, exercising sound medical judgment, who concludes that the miner suffers or suffered from pneumoconiosis. Such conclusion must be based on objective medical evidence and must be supported by a reasoned medical opinion. The medical opinion evidence has previously been summarized.

Dr. Rasmussen diagnosed pneumoconiosis based on his examination and testing of the Claimant which included a positive chest x-ray performed in conjunction with his examination. Pulmonary function studies showed a minimal, reversible obstructive defect and a markedly reduced diffusing capacity. Marked impairment in oxygen transfer was noted with exercise blood gas testing. He concluded that the degree of pulmonary impairment would disable the Claimant from his last coal mine employment and found that the only significant risk factor for his impaired lung function was his coal mine dust exposure.

Dr. Zaldivar found insufficient evidence for a diagnosis of pneumoconiosis or other dust disease of the lungs based on his examination and testing of the Claimant, as well as his review of medical records. He relied in part on the negative x-ray interpretation considered at the time of his examination. In addition, he reviewed other records including x-ray and CT readings which he found did not support a finding of pneumoconiosis. He attributed any irregular findings to interstitial edema resulting from coronary artery disease. He did diagnose a totally disabling respiratory impairment due to a significant diffusion abnormality which he attributed to the Claimant's coronary artery disease.

Dr Crisalli also failed to diagnose pneumoconiosis based on his examination and testing of the Claimant, as well as his review of other medical records. He indicated in his report that "chest x-ray shows no evidence of coal worker's pneumoconiosis, taking all of the x-ray reports as a whole." However, in his conclusion Dr. Crisalli does not mention that the x-ray done in conjunction with his examination was read as positive by Dr. Robert Smith, who is a Board Certified radiologist and B-reader, and who was the radiologist who performed the reading for Dr. Crisalli's office. His deposition testimony points out that negative readings were subsequently performed by other radiologists including Dr. Wheeler, although these rereadings were not done at his request. He found that the Claimant had significant respiratory impairment from the standpoint of oxygen transfer that would disable him from performing his regular coal mining job. He did not attribute this impairment to pneumoconiosis or other lung disease related to coal dust exposure. He also found Claimant's history of cigarette smoking to be insignificant and he did not believe his cardiac disease caused his pulmonary impairment. He recommended that the Claimant have further testing and attributed his pulmonary disability to an undiagnosed, undetermined lung condition.

Claimant's treating physician, Dr. Smith, did diagnose pneumoconiosis. The Regulations at 20 C.F.R. §718.104(d) set forth the criteria for determining the weight that should be accorded to the treating physician's opinion:

> d) Treating physician. In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:
>
> (1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;
>
> (2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;
>
> (3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and
>
> (4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.
>
> (5) In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility

of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

20 C.F.R. § 718.104(d).

In consideration of this criteria, it is noted that Dr. Lynn Smith's treatment records and testimony document periodic visits and ongoing treatment beginning in November of 1994, for a variety of diagnosed conditions which include coronary artery disease, hyperlipidemia, hypertension, and pneumoconiosis. Dr. Smith testified that the Claimant's symtomatology of lung disease began in about 1999. Pneumoconiosis was consistently diagnosed in the office records beginning in 2001. In addition to chest x-rays and a CT scan which Dr. Smith had considered, a cardiac stress test with ambulatory oximetry monitoring and desaturation was performed by his office. This showed a significant drop in values with exercise which he attributed to the underlying lung disease. He indicated that he has also reviewed pulmonary function studies performed in April of 2002. Dr. Smith testified that his diagnosis of pneumoconiosis was based on the Claimant's 33 year history of coal mine employment, positive chest x-rays and CT scan, his progressive lung disease, and the lack of other historical reasons for his lung disease. I find Dr. Smith's opinion to be well reasoned and supported by his testimony and treatment records as well as his qualifications as a Board Certified Internist. I give great weight to the opinion of Dr. Smith who has had the opportunity to observe and treat the Claimant on a regular basis over a period of more than ten years.

Dr. Robert Cohen, who is Board Certified in Internal Medicine and Pulmonary Diseases reviewed the available medical records and evidence in this case as indicated in his reports dated September 19, 2002, June 1, 2004, and November 9, 2004. Dr. Cohen diagnosed pneumoconiosis and concluded that the Claimant did not have the pulmonary functional capacity to perform his last coal mine employment. Dr. Cohen based his opinion on Claimant's long history of coal mine employment, his negligible smoking history, his progressive symptoms of lung disease for the previous 15- 20 years, and pulmonary function testing. I find Dr. Cohen's report to be thorough and well reasoned. In addition, his curriculum vitae reflects a high level of expertise not only in the field of pulmonary medicine but also in the field of occupational lung disease in coal miners. For these reasons I give the opinion of Dr. Cohen great weigh.

After considering all of the medical opinion evidence submitted in regard to Claimant's most recent claim for benefits, I find that the evidence does support a finding of pneumoconiosis. As previously discussed, I give great weight to the opinion of Dr. Cohen, based on his high level of expertise in the field of occupational medicine and pulmonary diseases. I also give great weight to the opinion of Dr. Smith, who is Claimant's treating physician, and who has had the opportunity to observe and treat the Claimant for more than ten years. Their diagnosis of pneumoconiosis is supported by Dr. Rasmussen, who also diagnosed pneumoconiosis based on his examination and testing of the Claimant. These opinions, which I find to be the most credible, represent a preponderance of the medical opinion evidence and outweigh the opinions of Drs. Zaldivar and Crisalli on the issue of coal worker's pneumoconiosis.

When the newly submitted evidence is considered as a whole, the record does support a finding of pneumoconiosis. As indicated, a preponderance of the medical opinion evidence

supports a determination of pneumoconiosis, as does a preponderance of the x-ray evidence. In addition, the record includes eight interpretations of a CT lung scan taken on July 1, 2002, which have previously been summarized. Drs. Maki, Capiello, Ahmed, Shipley and Spitz all found some indication of pneumoconiosis on this CT scan. Drs. Wheeler, Scott and Scatarige interpreted the CT as negative for pneumoconiosis. As a preponderance of these radiologists did find evidence of pneumoconiosis on the July 1, 2002 CT scan, I find this evidence also supports a finding of pneumoconiosis.

Thus, based on my review of all of the newly submitted evidence when considered as a whole, it is determined that Claimant has established the existence of pneumoconiosis. Since the newly submitted evidence does establish this element of entitlement, all of the evidence will be considered to determine whether Claimant has established entitlement to benefits.

In regard to the existence of pneumoconiosis I have also considered the new evidence in conjunction with the evidence submitted with the Claimant's previous application for benefits, all of which has been previously summarized. This earlier evidence was developed primarily between 1983 and 1988. Although a preponderance of the x-ray evidence and medical opinions did not establish pneumoconiosis at that time, this evidence was developed at least twelve years prior to the Claimant's most recent application for benefits which was filed on January 22, 2001. As pneumoconiosis is a progressive disease, I find the more recent evidence to be more probative of the Claimant's medical condition at the time of his recent application, as well as his current condition. Therefore, I give the new evidence greater weight.

Based on my review of all of the medical evidence and in particular, the new evidence which has been submitted with the current application for benefits, it is determined that the Claimant has established the existence of pneumoconiosis based on a preponderance of the recent x-ray evidence and medical opinion evidence. This evidence is also supported by the CT scan evidence and the record as a whole as previously discussed.

Cause of Pneumoconiosis

Once the Claimant is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. §718.203(a). If a Claimant who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). In this case, because the Claimant was employed in the coal mines for more than ten years, he is entitled to the benefit of the rebuttable presumption that pneumoconiosis arose out of coal mine employment. There being no evidence to the contrary, I find that Claimant's pneumoconiosis arose out of coal mine employment.

Total Disability Due To Pneumoconiosis

Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis. 20 C.F.R. §718.204(a)(2000). Total disability is defined as pneumoconiosis which prevents or prevented a Claimant from performing his usual coal mine employment.

The regulations at § 718.204(b) provide the following five methods to establish total disability: (1) qualifying pulmonary function studies; (2) qualifying blood gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure;[7] (4) reasoned medical opinions; and (5) lay testimony.[8]

Total disability may be established through a preponderance of qualifying pulmonary function studies. The quality standards for pulmonary function studies are located at 20 C.F.R. § 718.103 and require, in relevant part, that each study be accompanied by three tracings, *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984), and that the reported FEV1 and FVC or MVV values constitute the best efforts of three trials. The administrative law judge may accord lesser weight to those studies where the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984). To be qualifying, the regulations provide that the FEV1 and either the MVV or FVC values must be equal to or fall below those values listed at Appendix B for a miner of similar gender, age, and height.

The pulmonary function study evidence has previously been summarized. There are eight pulmonary function studies in the record with three of these studies being performed in the last five years. None of these studies indicate qualifying values. Accordingly, I find that the pulmonary function study evidence does not establish total disability pursuant to 20 C.F.R. §718.204(b)(2)(i).

Total disability may also be established by qualifying blood gas studies under Section 718.204(c)(2). In order to be qualifying, the PO2 values corresponding to the PCO2 values must be equal to or less than those found at the table at Appendix C.

The blood gas study evidence has previously been summarized. The record includes six studies, with three studies being performed in the last five years. When the most recent studies are considered the resting values are nonqualifying. However, the only two exercise blood gas studies performed in the last five years both indicate qualifying values. This would indicate an impairment of oxygen transfer with exercise or exertion. Therefore, it is determined that the blood gas test evidence does support a determination of total disability pursuant to 20 C.F.R. §718.204(b)(2)(ii).

Another method by which Claimant can establish total disability is through medical opinion evidence wherein a physician has exercised reasoned medical judgment based on medically acceptable clinical and laboratory diagnostic techniques to conclude that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment or comparable employment. 20 C.F.R. § 718.204(b)(2)(iv). The medical opinion evidence in the record has previously been summarized.

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[7] There is no evidence of cor pulmonale with right-sided congestive heart failure such that this method of establishing total disability will not be discussed further.

[8] The Board has held that a judge cannot rely solely upon lay evidence to find total disability in a living miner's claim. *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

Although they differ in regard to the cause of his respiratory and pulmonary impairment, Drs. Rasmussen, Zaldivar, Crisalli and Cohen all concluded that the Claimant suffered from a totally disabling pulmonary or respiratory condition. All of these physicians pointed to the diffusion impairment evident on the recent pulmonary function studies and the significant gas exchange abnormalities that were seen on the blood gas tests that were performed with exercise. Dr. Rasmussen stated that the pulmonary function studies indicate marked loss of lung function as reflected by significantly reduced single breath diffusing capacity and the impairment in oxygen transfer during exercise. He further stated that the degree of impairment would prevent the Claimant from resuming his last coal mine job. Dr. Zaldivar indicated that the Claimant had a respiratory impairment due to a low diffusing capacity and that, from a respiratory standpoint, Claimant would be unable to do his usual coal mining work. Dr. Crisalli indicated that the Claimant had significant respiratory impairment from the standpoint of oxygen transfer, and that he would be unable to perform his regular coal mining job. Dr. Cohen concluded that Claimant clearly did not have the pulmonary function capacity to perform his last coal mining job, pointing to his mild obstructive lung disease, severe diffusion impairment, and severe gas exchange abnormalities with exercise.

In addition, Dr. Smith, Claimant's treating physician, concluded that Claimant was totally disabled due to his pulmonary impairment and his coronary heart disease. He attributed his pulmonary impairment to his pneumoconiosis and indicated that it contributed to his total disability. He did not reach a conclusion on whether the pulmonary impairment would be totally disabling when considered by itself.

Thus, a preponderance of the recent medical opinion evidence, along with the blood gas test evidence does support a finding that the Claimant suffered from a totally disabling pulmonary or respiratory impairment.

Etiology of Total Disability

Claimant must also prove that pneumoconiosis was a "contributing cause" to his disability. *Hobbs v. Clinchfield Coal Co.,* 917 F. 2d 790, 792(4th Cir. 1990); *Robinson v. Pickands Mather & Co.,* 914 F. 2d 35,38(1990). Non-respiratory and non-pulmonary impairments have no bearing on establishing total disability due to pneumoconiosis and a miner must show that he has a totally disabling respiratory or pulmonary condition, and that pneumoconiosis is a contributing cause to this disabling condition. *Jewell Smokeless Coal Corp. v. Street,* 42 F.3d 241 (4th Cir. 1994).

As previously discussed the medical opinion evidence along with the exercise blood gas study evidence establishes that the Claimant does have a totally disabling respiratory or pulmonary condition. The medical evidence considered as a whole, also establishes the existence of pneumoconiosis. It must also be shown that the Claimant's pneumoconiosis contributed to his total disability.

The medical opinion evidence is divided on the cause of the Claimant's pulmonary condition. Dr. Cohen, who is a highly qualified expert in the field of pulmonary medicine and occupational diseases, attributed the Claimant's pulmonary disease to his pneumoconiosis and his coal mine dust exposure. He stated that the Claimant's 33 year history of coal mine dust exposure was significantly contributory to the development of his mild obstructive lung disease, severe diffusion impairment, and his severe gas exchange abnormalities with exercise. He points out that the Claimant had a negligible smoking history which he did not believe contributed at all to his impairment. He further stated that it "is a classic finding that the interstitial lung disease caused by coal mine dust causes diffusion impairment and gas exchange abnormalities." Dr. Cohen's opinion is supported by Dr. Rasmussen who indicated that the Claimant's coal mine dust exposure was the only significant risk factor for his lung impairment. He also stated that the pattern of the Claimant's impairment strongly suggested that it was the result of coal mine dust exposure rather than cigarette smoking. Claimant's treating physician, Dr. Smith, also attributed the Claimant's pulmonary disease to his 33 year history of coal mine employment. He testified during deposition that "to date, the only working diagnosis that we have for his lung disease is occupational exposure to coal dust."

Dr. Zaldivar attributed the Claimant's disabling respiratory disease to his coronary artery disease and interstitial edema resulting therefrom. He points to the fact that the Claimant's diffusion impairment did not appear until two years after the Claimant's coal mine employment ended. Dr. Cohen addressed this argument in his September 19, 2002 report where he cites extensive medical literature which indicates that pneumoconiosis is a progressive disease, and that it is not uncommon for symptoms and clinical evidence of the disease to progress, after coal mine dust exposure has terminated. Dr. Smith also testified that he frequently sees and treats coal miners with pneumoconiosis as a regular part of his medical practice, and he found it to be very common for pneumoconiosis to progress after an individual ceases exposure to coal mine dust. Dr. Smith also testified that he found nothing on Claimant's cardiac work-ups to explain a cardiac source for Claimant's abnormalities. Dr. Crisalli also testified during his deposition that he did not believe that the Claimant's diffusion impairment was related to his cardiac disease. Dr. Crisalli indicated however, that he believed the Claimant's pulmonary impairment was due to some other lung disease which had not yet been determined or diagnosed.

After reviewing all of the medical opinion evidence I find that a preponderance of the medical opinion evidence, and that which I find to be the most credible, attributes the Claimant's respiratory/pulmonary disease and impairment to his pneumoconiosis, resulting from his 33 year history of coal mine dust exposure. I give great weight to the opinion of Dr. Cohen who has a great deal of expertise in the area of pulmonary disease and the effects of occupational exposure. I also give great weight to the Claimant's treating physician, Dr. Smith, who has treated Claimant on a regular basis for the last ten years and is therefore very familiar with the progression of his medical condition during this time period. Their opinion that Claimant's pulmonary disease is related to his occupational exposure to coal mine dust is supported by Dr. Rasmussen, who concluded that coal mine dust exposure was the only risk factor for Claimant's lung impairment.

I find Dr. Zaldivar's opinion that Claimant's disabling lung impairment was related to cardiac disease is against the weight of the evidence, including the opinion of Claimant's treating

physician. The opinion of Dr. Crisalli that Claimant's impairment is due to some undetermined and undiagnosed condition is also found to be contrary to the weight of the medical evidence.

I also find the opinions of Dr. Cohen, Smith, and Rasmussen to be supported by the exercise blood gas test evidence and the medical record when viewed as a whole. I have reviewed the other medical evidence including the earlier medical opinions which were developed at the time of Claimant's earlier application for benefits, but I do not find them to be as probative as the more recent evidence regarding Claimant's current medical condition and his condition at the time of his most recent application for benefits, especially in light of the fact that pneumoconiosis is a progressive disease.

For the reasons stated above, I find that the Miner's pneumoconiosis was a contributing cause to his totally disabling respiratory and pulmonary condition. Thus, Claimant has established that he is totally disabled due to pneumoconiosis arising out of his coal mine employment. Therefore, he is entitled to black lung benefits.

Onset Date of Entitlement

Claimant is entitled to benefits as of January 1, 2001. Where as in this case, the evidence does not establish a specific onset of disability, benefits are payable from the first day of the month in which Claimant filed his application for benefits. 20 C.F.R. §725.503.

Attorney Fees

An application by Claimant's attorney for approval of a fee has not been received and, therefore, no award of attorney's fees for services is made. Thirty days is allowed to Claimant's counsel for the submission of such an application and attention is directed to § 725.365 and § 725.366 of the regulations. A service sheet showing that service has been made upon all parties, including Claimant, must accompany the application. Parties have ten days following the receipt of any such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

Westmoreland Coal Company is ordered to:

1. Pay to the Claimant, Clyde C. Belcher all benefits to which he is entitled commencing on January 1, 2001, augmented by reason of his dependent wife, Loretta, and his adopted daughter, Jessica, during the period of her dependency pursuant to the regulations.

2. Reimburse the Black Lung Disability Trust Fund for all benefits paid to Claimant, deducting such amounts due under paragragh 1, above.

3. Pay to the Black Lung Disability Trust Fund any interest owed on benefit payments made by the Trust Fund, pursuant to the regulations.

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Thomas M. Burke
Associate Chief Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is:

Benefits Review Board

U.S. Department of Labor

P.O. Box 37601

Washington, DC 20013-7601.

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).